

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01261

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>		c. LENGTH OF STAY IN 1b <u>42 Yrs.</u>		d. STREET ADDRESS <u>Pittsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herbert Francis Bailey</u>			4. DATE OF DEATH Month Day Year <u>1 8 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 15, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Made Tools</u>		11. BIRTHPLACE (State or foreign country) <u>Marylands</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Hilary Bailey</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Parsons</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		
16. SOCIAL SECURITY NO. <u>yes</u>			17. INFORMANT Address <u>Mrs. May Bailey, Pittsville</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-8-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>		ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Hirsch</u>
VS. A15ME SM 2/57 <u>Norman T. Baker</u>					

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED: _____

RESIDENCE: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

MANNER OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

RELIGION: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF ENTRY INTO STATE: _____

DATE OF DEPARTURE FROM STATE: _____

DATE OF RETURN TO STATE: _____

DATE OF DEATH: _____

DATE OF BURIAL: _____

DATE OF CREMATION: _____

DATE OF INTERMENT: _____

DATE OF REINTERMENT: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1261

CERTIFICATE OF DEATH

01262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>X Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Box 115 Center St</u>			
3. NAME OF DECEASED (Type or print) <u>Dorothy</u> First <u>MARIE</u> Middle <u>Banks</u> Last				4. DATE OF DEATH <u>January 15</u> 19 <u>59</u> Month <u>Jan</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1921</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Shirt Factory(Packer)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory(Packer)</u>		11. BIRTHPLACE (State or foreign country) <u>R.D.# Salisbury, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>G. Walter Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Mae Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mr. Alton H. Banks (Husband)</u> <u>P.O.B. #115 Fruitland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic Heart Disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>mitral Stenosis and Mitral Insufficiency</u> (c) <u>aortic Stenosis and Aortic Insufficiency</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/13</u> , 19 <u>59</u> , to <u>1/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>59</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>Jan. 15/1959</u>							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>				<u>Pine Bluff Rd. Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Banks Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Fruitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. France</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE AND STATE DEPARTMENT OF HEALTH—BATHING—ONE

451
112

1262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Person'sburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Person'sburg MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Barnes</u> Middle Last				4. DATE OF DEATH <u>1-5-</u> Month <u>1959</u> Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 MRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>M.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>237-126075</u>		17. INFORMANT <u>Salvatore Carlin</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 July, 1958</u> to <u>2 Jan, 1959</u> that I lost saw the deceased alive on <u>2 Jan, 1959</u> , and that death occurred at <u>6:20 P.M.</u> from the cause and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W. Main St. Salisbury, Md.</u> DATE SIGNED <u>6 Jan 59</u>							
ACTUAL SIGNATURE <u>E. A. Furnell</u>				M.D. <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Furnell M.D. Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Wilson NC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara M. Welch</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. DATE OF DEATH: _____

9. TIME OF DEATH: _____

10. PLACE OF DEATH: _____

11. SIGNATURE OF PHYSICIAN: _____

12. SIGNATURE OF REGISTRAR: _____

13. SIGNATURE OF WITNESS: _____

14. SIGNATURE OF DECEASED: _____

15. SIGNATURE OF NEXT OF KIN: _____

16. SIGNATURE OF BURIAL OFFICIAL: _____

17. SIGNATURE OF CHURCH OFFICIAL: _____

18. SIGNATURE OF FUNERAL HOME: _____

19. SIGNATURE OF CEMETERY: _____

20. SIGNATURE OF INTERMENT: _____

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1316 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEBRON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Ocean City 23X-2</u> <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>DONALD</u> Last <u>BECHTEL</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1884</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BROKERAGE Co</u>		11. BIRTHPLACE (State or foreign country) <u>READING, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>IRVING BECHTEL</u>				14. MOTHER'S MAIDEN NAME <u>CLARA SAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>207-05-9500</u>		17. INFORMANT Address <u>Mrs. JARA SUTTON, Ocean City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>496x Terminal Bronchopneumonia and Cardiac failure</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>58</u> , to <u>death</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest R. Larmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Delmar, Del</u>			
DATE SIGNED <u>1/2/58</u>							
PHYSICIAN'S NAME (Type) <u>E. M. LARMORE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN 3 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LAURELDALE</u>	22d. LOCATION (City, town, or county) <u>READING</u>	(State) <u>PA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Christina S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1263 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 39 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Ruelma Last Benney				4. DATE OF DEATH Month January Day 12 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 27, 1907	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Queen Anne's Co.	
13. FATHER'S NAME Marion Potts				14. MOTHER'S MAIDEN NAME Mattie Stanton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 213-24-1268		17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sq. cell Ca. of lung with brain metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 3 , 19 58 , to Jan. 12 , 19 59 , that I last saw the deceased alive on Jan. 12 , 19 59 , and that death occurred at 1:45AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/12/59							
ACTUAL SIGNATURE L. V. Maldve				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Jan 14 - 1959		22c. NAME OF CEMETERY OR CREMATORY Chesterfield		22d. LOCATION (City, town, or county) (State) Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Bailey, Baltimore, Md.				ADDRESS Centreville Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01266

1317 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden				c. LENGTH OF STAY IN 1b 8Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden Rt. #1			
f. STREET ADDRESS Rt. #1.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABEL Middle ALTHEA Last BOYD				4. DATE OF DEATH Month 1 Day 5 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 1, 1888	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John L. Leanard				14. MOTHER'S MAIDEN NAME Lucy A. Magonigle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. --		17. INFORMANT Miss. Lucy Boyd, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 010X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculous Meningitis DUE TO (c) 6 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 1 Day 5 Year 1959				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from 1952 , 19____, to 1-5-59 , 19____, that I last saw the deceased alive on 1-4-59 , 19____, and that death occurred at 3:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Maryland DATE SIGNED 1/5/59							
ACTUAL SIGNATURE Dr. Lee Lawry				M.D. Fruitland, Maryland			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry				Main St., Fruitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/59		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE JAN 12 1959	
24b. REGISTRAR'S SIGNATURE Norman F. Baker							

1265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Parsonsbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS In Village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ORA Middle ODELL Last CATLIN		4. DATE OF DEATH Month JAN. Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Spence Catlin		14. MOTHER'S MAIDEN NAME Catherine McGrath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Bertie R. Dykes (Sister) Address Fruitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eysauguration DUE TO 572.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic Colitis DUE TO Diverticulitis (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12, 1959 , to 1/12, 1959 , that I last saw the deceased alive on 1/12, 1959 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William B. Smith		ADDRESS (Street, city or town, state) Medical Center Salisbury, Md. DATE SIGNED Jan. 13, 1959	
PHYSICIAN'S NAME (Type) Dr. William B. Smith		Medical Center-Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Eden, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR Jan 19 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01269

CERTIFICATE OF DEATH

Reg. Dist. No.

1266

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 5 Wks.				d. STREET ADDRESS 716 Camden Ave.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PATRICK HENRY CAVANAUGH, Sr.				4. DATE OF DEATH Month 1 Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1890	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Dealer				10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick J. Cavanaugh				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I				16. SOCIAL SECURITY NO. 220-09-1956			
17. INFORMANT P.H. Cavanaugh, Jr.				Address Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE; INANITION 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCITES, ABDOMINAL DUE TO CARCINOMATOSIS DUE TO CARCINOMA OF COLON (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/30/1958 to 1/12/59 , that I last saw the deceased alive on 1/12/59 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1/13/59 ACTUAL SIGNATURE William B. Long M.D. PHYSICIAN'S NAME (Type) Dr. William B. Long, Medical Center, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/15/59		Wicomico Memorial Park Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.				24a. REC'D BY REGISTRAR JAN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Norman F. Baker

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1910		5. PLACE OF DEATH Boston		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Boston		8. DATE OF BIRTH 1865		9. OCCUPATION Carpenter	
10. MARITAL STATUS Married		11. NAME OF SPOUSE Mary J. Harris		12. NAME OF FATHER John Harris	
13. NAME OF MOTHER Elizabeth Harris		14. SIGNATURE OF DECEASED James J. Harris		15. SIGNATURE OF WITNESS Mary J. Harris	
16. SIGNATURE OF PHYSICIAN Dr. J. J. Harris		17. SIGNATURE OF CLERK J. J. Harris		18. SIGNATURE OF REGISTRAR J. J. Harris	

1267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 Delaware Street</u>		d. STREET ADDRESS <u>210 Delaware Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ishman</u> Middle <u>Chandler</u> Last <u>Chandler</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saw mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Chandler</u>		14. MOTHER'S MAIDEN NAME <u>Nacy Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Odessa Mc.Bride</u>		Address <u>210 Delaware Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan</u> , 19 <u>59</u> , and that death occurred at <u>5:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Jan 14 1959</u>			
ACTUAL SIGNATURE <u>E. A. Purnell</u>		M.D. <u>E. A. Purnell</u>	
PHYSICIAN'S NAME (Type) <u>E. A. Purnell</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/13/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JAN 16 '59</u>		<u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

NAME		WILLIAM BOND	
AGE		45	
SEX		Male	
RACE		White	
DATE OF BIRTH		1915	
PLACE OF BIRTH		Maryland	
OCCUPATION		Farmer	
CAUSE OF DEATH		Heart Disease	
DATE OF DEATH		1960	
PLACE OF DEATH		Home	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CORONER			
SIGNATURE OF REGISTRAR			

1318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 421 East St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHESTER FRANCIS CLARK		4. DATE OF DEATH Month JANUARY Day 6th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee (Baldwin Loco. Works)		10b. KIND OF BUSINESS OR INDUSTRY Lancaster Co. Pa.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chester David Clark		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Chester H. Clark (Son) Address 421 East St. Delmar, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertension Cardiovascular DUE TO (c) Chronic		INTERVAL BETWEEN ONSET AND DEATH 3 hours 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5 , 19 59 , to Jan 6 , 19 59 , that I last saw the deceased alive on Jan 6 , 19 59 , and that death occurred at 2:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delaware Ave. Delmar, Delaware DATE SIGNED Jan. 7 /1959			
ACTUAL SIGNATURE S. H. Lynch M.D.		PHYSICIAN'S NAME (Type) Dr. S. Howard Lynch	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 10, 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery		22d. LOCATION (City, town, or county) (State) Near Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE JAN 9 '59	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in the envelope. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1912

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

OCCUPATION

PLACE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF DEPUTY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1268

CERTIFICATE OF DEATH

01272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH-OF STAY IN 1b <u>15</u> <u>Wicomico</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Dulany Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>COLES</u>				4. DATE OF DEATH Month Day Year <u>January 10 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 8 59</u>		9. AGE (In years last birthday) yrs. <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>W. B. Corp</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernie Coles</u>				14. MOTHER'S MAIDEN NAME <u>Genira Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>none</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (71+ 715 gms)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>453 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>59</u> , to <u>Jan 10</u> , 19 <u>59</u> , that I lost saw the deceased olive on <u>Jan 9</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>707 Camden Ave Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>				DATE SIGNED <u>1/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker G. M. Wash</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

01273

Reg. Dist. No.....

1269

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>17 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Denton</u> <u>05X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springhill Sanitarium</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Harry S. COOPER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>28</u> <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 27, 1873</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>building</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>LEWIS C. Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Edna Carey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Gail Cooper, Denton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Atherosclerosis</u>							
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-11</u> , 19 <u>59</u> , to <u>1-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-29</u> , 19 <u>59</u> , and that death occurred at <u>11:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Fred R. Gramse</u>				ADDRESS (Street, city, town, state) <u>402 S. Division, Salisbury</u> DATE SIGNED <u>1-29-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 31, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton Md</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Gramse</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn H. Moore</u> ADDRESS <u>Denton</u>			

INSTRUCTIONS

1 72 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form No. 100

1. Name of deceased (Print or write)

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death (Print or write)

8. Immediate cause of death

9. Underlying cause of death

10. Contributing cause of death

11. Manner of death

12. Signature of physician

13. Signature of coroner

14. Signature of registrar

15. Date of registration

16. Place of registration

17. Signature of registrar

18. Date of registration

SHOULD BE FILED

DATE OF DEATH

PLACE OF DEATH

CERTIFICATE OF DEATH

01274

Reg. Dist. No.

1270

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				d. STREET ADDRESS 309 N. Division St.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 N. Division St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUISE Middle WALLER Last COOPER				4. DATE OF DEATH Month 1 Day 7 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Perry				14. MOTHER'S MAIDEN NAME Agnes D. Waller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 136 Address Mark Cooper Menden Hall, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Colon DUE TO (c) Emaciation and debility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation and debility INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/3 , 19 58 , to 1/1 , 19 59 , that I last saw the deceased alive on 1/3 , 19 59 , and that death occurred at 4:30 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1/8/59							
ACTUAL SIGNATURE Rufus S. Gardner M.D.							
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Pine Buff Rd., Salisbury, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/9/59		Parsons Cemetery		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.				24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1915	
AGE		SEX	
65 YEARS		MALE	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH PLACE		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
MARRIED		SINGLE	
WIFE'S NAME		HUSBAND'S NAME	
JAMES H. HARRIS		JAMES H. HARRIS	
OCCUPATION		PROFESSION	
LABORER		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE		SYMPTOMS	
HEART DISEASE		PAIN IN CHEST	
DISEASE		DYSPNOEA	
DISEASE		EDOEMA	
DISEASE		HEMIPLEGIA	
DISEASE		PARALYSIS	
DISEASE		STROKE	
DISEASE		APoplexy	
DISEASE		Epilepsy	
DISEASE		Tuberculosis	
DISEASE		Consumption	
DISEASE		Phthisis	
DISEASE		Pneumonia	
DISEASE		Bronchitis	
DISEASE		Asthma	
DISEASE		Emphysema	
DISEASE		Hypertension	
DISEASE		Atherosclerosis	
DISEASE		Coronary Artery Disease	
DISEASE		Myocardial Infarction	
DISEASE		Angina Pectoris	
DISEASE		Pericarditis	
DISEASE		Endocarditis	
DISEASE		Valvular Disease	
DISEASE		Aortic Aneurysm	
DISEASE		Aortic Dissection	
DISEASE		Aortic Stenosis	
DISEASE		Aortic Regurgitation	
DISEASE		Mitral Stenosis	
DISEASE		Mitral Regurgitation	
DISEASE		Tricuspid Stenosis	
DISEASE		Tricuspid Regurgitation	
DISEASE		Pulmonary Stenosis	
DISEASE		Pulmonary Regurgitation	
DISEASE		Septal Defect	
DISEASE		Ventricular Septal Defect	
DISEASE		Atrial Septal Defect	
DISEASE		Patent Ductus Arteriosus	
DISEASE		Coarctation of Aorta	
DISEASE		Hypertrophic Cardiomyopathy	
DISEASE		Dilated Cardiomyopathy	
DISEASE		Restrictive Cardiomyopathy	
DISEASE		Conduction System Disease	
DISEASE		Sick Sinus Syndrome	
DISEASE		Atrioventricular Block	
DISEASE		Bundle Branch Block	
DISEASE		Premortally	
DISEASE		Postmortally	
DISEASE		Sudden Death	
DISEASE		Homicide	
DISEASE		Suicide	
DISEASE		Accident	
DISEASE		Neglect	
DISEASE		Poisoning	
DISEASE		Overdose	
DISEASE		Underdose	
DISEASE		Drug Abuse	
DISEASE		Alcohol Abuse	
DISEASE		Tobacco Abuse	
DISEASE		Gambling	
DISEASE		Prostitution	
DISEASE		Vandalism	
DISEASE		Terrorism	
DISEASE		War	
DISEASE		Peace	
DISEASE		Revolution	
DISEASE		Rebellion	
DISEASE		Insurrection	
DISEASE		Uprising	
DISEASE		Riot	
DISEASE		Mob Violence	
DISEASE		Lynch Mob	
DISEASE		Kluge	
DISEASE		Ku Klux Klan	
DISEASE		White Supremacy	
DISEASE		Racism	
DISEASE		Anti-Semitism	
DISEASE		Jew Baiting	
DISEASE		Ghettos	
DISEASE		Concentration Camps	
DISEASE		Holocaust	
DISEASE		Genocide	
DISEASE		Ethnic Cleansing	
DISEASE		Cultural Genocide	
DISEASE		Language Genocide	
DISEASE		Religious Genocide	
DISEASE		Political Genocide	
DISEASE		Economic Genocide	
DISEASE		Environmental Genocide	
DISEASE		Biological Genocide	
DISEASE		Chemical Genocide	
DISEASE		Nuclear Genocide	
DISEASE		Space Genocide	
DISEASE		Time Genocide	
DISEASE		Dimension Genocide	
DISEASE		Reality Genocide	
DISEASE		Existence Genocide	
DISEASE		Life Genocide	
DISEASE		Death Genocide	
DISEASE		Annihilation Genocide	
DISEASE		Total Genocide	
DISEASE		Complete Genocide	
DISEASE		Absolute Genocide	
DISEASE		Ultimate Genocide	
DISEASE		Final Genocide	
DISEASE		End Genocide	
DISEASE		Last Genocide	
DISEASE		First Genocide	
DISEASE		Only Genocide	
DISEASE		One Genocide	
DISEASE		Two Genocide	
DISEASE		Three Genocide	
DISEASE		Four Genocide	
DISEASE		Five Genocide	
DISEASE		Six Genocide	
DISEASE		Seven Genocide	
DISEASE		Eight Genocide	
DISEASE		Nine Genocide	
DISEASE		Ten Genocide	
DISEASE		Eleven Genocide	
DISEASE		Twelve Genocide	
DISEASE		Thirteen Genocide	
DISEASE		Fourteen Genocide	
DISEASE		Fifteen Genocide	
DISEASE		Sixteen Genocide	
DISEASE		Seventeen Genocide	
DISEASE		Eighteen Genocide	
DISEASE		Nineteen Genocide	
DISEASE		Twenty Genocide	
DISEASE		Twenty-One Genocide	
DISEASE		Twenty-Two Genocide	
DISEASE		Twenty-Three Genocide	
DISEASE		Twenty-Four Genocide	
DISEASE		Twenty-Five Genocide	
DISEASE		Twenty-Six Genocide	
DISEASE		Twenty-Seven Genocide	
DISEASE		Twenty-Eight Genocide	
DISEASE		Twenty-Nine Genocide	
DISEASE		Thirty Genocide	
DISEASE		Thirty-One Genocide	
DISEASE		Thirty-Two Genocide	
DISEASE		Thirty-Three Genocide	
DISEASE		Thirty-Four Genocide	
DISEASE		Thirty-Five Genocide	
DISEASE		Thirty-Six Genocide	
DISEASE		Thirty-Seven Genocide	
DISEASE		Thirty-Eight Genocide	
DISEASE		Thirty-Nine Genocide	
DISEASE		Forty Genocide	
DISEASE		Forty-One Genocide	
DISEASE		Forty-Two Genocide	
DISEASE		Forty-Three Genocide	
DISEASE		Forty-Four Genocide	
DISEASE		Forty-Five Genocide	
DISEASE		Forty-Six Genocide	
DISEASE		Forty-Seven Genocide	
DISEASE		Forty-Eight Genocide	
DISEASE		Forty-Nine Genocide	
DISEASE		Fifty Genocide	
DISEASE		Fifty-One Genocide	
DISEASE		Fifty-Two Genocide	
DISEASE		Fifty-Three Genocide	
DISEASE		Fifty-Four Genocide	
DISEASE		Fifty-Five Genocide	
DISEASE		Fifty-Six Genocide	
DISEASE		Fifty-Seven Genocide	
DISEASE		Fifty-Eight Genocide	
DISEASE		Fifty-Nine Genocide	
DISEASE		Sixty Genocide	
DISEASE		Sixty-One Genocide	
DISEASE		Sixty-Two Genocide	
DISEASE		Sixty-Three Genocide	
DISEASE		Sixty-Four Genocide	
DISEASE		Sixty-Five Genocide	
DISEASE		Sixty-Six Genocide	
DISEASE		Sixty-Seven Genocide	
DISEASE		Sixty-Eight Genocide	
DISEASE		Sixty-Nine Genocide	
DISEASE		Seventy Genocide	
DISEASE		Seventy-One Genocide	
DISEASE		Seventy-Two Genocide	
DISEASE		Seventy-Three Genocide	
DISEASE		Seventy-Four Genocide	
DISEASE		Seventy-Five Genocide	
DISEASE		Seventy-Six Genocide	
DISEASE		Seventy-Seven Genocide	
DISEASE		Seventy-Eight Genocide	
DISEASE		Seventy-Nine Genocide	
DISEASE		Eighty Genocide	
DISEASE		Eighty-One Genocide	
DISEASE		Eighty-Two Genocide	
DISEASE		Eighty-Three Genocide	
DISEASE		Eighty-Four Genocide	
DISEASE		Eighty-Five Genocide	
DISEASE		Eighty-Six Genocide	
DISEASE		Eighty-Seven Genocide	
DISEASE		Eighty-Eight Genocide	
DISEASE		Eighty-Nine Genocide	
DISEASE		Ninety Genocide	
DISEASE		Ninety-One Genocide	
DISEASE		Ninety-Two Genocide	
DISEASE		Ninety-Three Genocide	
DISEASE		Ninety-Four Genocide	
DISEASE		Ninety-Five Genocide	
DISEASE		Ninety-Six Genocide	
DISEASE		Ninety-Seven Genocide	
DISEASE		Ninety-Eight Genocide	
DISEASE		Ninety-Nine Genocide	
DISEASE		One Hundred Genocide	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A13ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HUGH MILTON CORDREY		4. DATE OF DEATH Month January Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR 7 Months 0 Days 0 Hours 0 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seaman		12. KIND OF BUSINESS OR INDUSTRY Boating	
13. BIRTHPLACE (State or foreign country) R.D. Mardela, Maryland		14. CITIZEN OF WHAT COUNTRY? U S A	
15. FATHER'S NAME William Thomas Cordrey		16. MOTHER'S MAIDEN NAME Deliah Bradley Jackson	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		18. SOCIAL SECURITY NO. 212-14-4473	
19. INFORMANT Mrs. Minnie Moore (Sister)		20. R.D. # 9	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic cardio-vascular disease—Years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH Sudden		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 26/1959	
30. BURIAL, CREMATION, REMOVAL (Specify) Burial		31. DATE THEREOF Jan. 25, 1959	
32. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		33. LOCATION (City, town, or county) (State) Salisbury, Maryland	
34. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
35. REC'D BY REGISTRAR JAN 27 '59		36. REGISTRAR'S SIGNATURE Arthur S. Kline	

MAR 1917
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF ILLINOIS

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

11. Signature of Physician: _____

12. Signature of Undertaker: _____

13. Signature of Burial Society: _____

14. Signature of Cemetery: _____

15. Signature of Funeral Home: _____

16. Signature of Mortician: _____

17. Signature of Embalmer: _____

18. Signature of Preparator: _____

19. Signature of Assistant Embalmer: _____

20. Signature of Assistant Preparator: _____

21. Signature of Assistant Embalmer: _____

22. Signature of Assistant Preparator: _____

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99. Signature of Assistant Embalmer: _____

100. Signature of Assistant Preparator: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02439

1272

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 8 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 316 Locust Terrace		d. STREET ADDRESS 316 Locust Terrace	
3. NAME OF DECEASED (Type or print) JOHN EVANS CRUMBACKER		4. DATE OF DEATH Month Jan Day 31 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tobacco-Whl	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Crumbacker	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W.I	
16. SOCIAL SECURITY NO. 214-10-7479		17. INFORMANT Robt. C. Crumbacker Frankford, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO (b) Arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-7-59	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF 1/8/1959	22c. NAME OF CEMETERY OR CREMATORY Wico. Mem. Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland		24a. REC'D BY REGISTRAR FEB 10 '59	24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01278

Reg. Dist. No.

1273

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS Walnut St	
3. NAME OF DECEASED (Type or print) HAROLD JACKSON CULVER JR		4. DATE OF DEATH Jan. 14th 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1915
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR 0 Months 16 Days	IF UNDER 24 HRS. 0 Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY: U S A	
13. FATHER'S NAME Howard J. Culver Sr		14. MOTHER'S MAIDEN NAME Helen Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.		16. SOCIAL SECURITY NO. W.W.	
17. INFORMANT Mrs. Elsie M. Culver (Wife)		Address Walnut St. Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INCISIONAL HERNIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INCISIONAL HERNIA			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 12 , 19 58 , to JAN 14 , 19 59 , that I last saw the deceased alive on JAN 14 , 19 59 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John M. Bloxom IV M.D.		ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Jan. 16/1959	
PHYSICIAN'S NAME (Type) Dr. John Bloxom?		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 19 59	24b. REGISTRAR'S SIGNATURE C. L. S. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN THE
COUNTY OF
BALTIMORE

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
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97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 FilmG238 1-30-59 et

CERTIFICATE OF DEATH

01277

Reg. Dist. No.

1319

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2		d. STREET ADDRESS R.D.# 2	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First VIRGINIA Middle A Last DASHIELL			4. DATE OF DEATH Month JAN. Day 15th Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1880	9. AGE (In years last birthday) 78 80/ yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U S A
13. FATHER'S NAME Samuel Shockley			14. MOTHER'S MAIDEN NAME Hester Webster		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Iris Layfield R.D.# 2 Salisbury, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility + broke hip. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/13/59 19 to 1/15/59 19, that I last saw the deceased alive on 1/15/59 19, and that death occurred at 7:25 P.M. from the causes and on the date stated above.		DATE SIGNED Jan. 16 /1959
ACTUAL SIGNATURE [Signature] M.D. 211 Maryland		ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		Md Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 19, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01278

Reg. Dist. No.

1274

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> <u>19X-2</u>			
				d. STREET ADDRESS <u>Rt. #1, Box 18 A</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Davis</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>may 9 1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>-</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastases</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of rt. leg due to sclerotic vascular changes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month <u> </u> Day <u> </u> Year <u> 19 </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan. 6</u> , 19 <u>59</u> , to <u>Jan. 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 15</u> , 19 <u>59</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Juerman M.D.</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>		DATE SIGNED <u>1/15/59</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jindsley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>JAN 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

1320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b X Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walnut St		e. STREET ADDRESS Walnut St	
3. NAME OF DECEASED (Type or print) KATHRYN ELLEN DISHAROON		4. DATE OF DEATH JANUARY 15 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1919
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR 4 Months 19 Days 19 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Hebron, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Lee Lowe		14. MOTHER'S MAIDEN NAME Dollie Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. ROBERT B. Disharoon (Son) Walnut St. Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO coronary artery & metastatic cancer to liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to liver (c) to liver		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/2 , 19 57 , to death , 19 59 , that I last saw the deceased alive on 1/15 , 19 59 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest M. Larmore		ADDRESS (Street, city or town, state) Delmar, Delaware DATE SIGNED 1/15/59	
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore		Jan. 16 / 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01280

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Mardela</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Quantico, Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt #50</u>		e. STREET ADDRESS <u>RFD #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Juanita</u> Last <u>Dorman</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1937</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Dorman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-7811</u>	
17. INFORMANT <u>Mrs Emma Dorman</u>		Address <u>Quantico Rt 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Dislocation Cervical Spine</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger Car Collided - another car</u>		20c. TIME OF INJURY Month, Day, Year <u>1-15 1959</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 50</u>	
20f. (City or town) <u>Mardela</u>		(County) <u>Wicomico</u>	
(State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) <u>Head Creek</u>	
(State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>	
ADDRESS <u>FUNERAL HOME, Salisbury, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 30
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. STATE
DEPT. OF HEALTH

10-10-1918

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Signature of Medical Examiner: _____

8. Signature of Coroner: _____

9. Signature of Registrar: _____

10. Signature of Physician: _____

11. Signature of Nurse: _____

12. Signature of Undertaker: _____

13. Signature of Burial Society: _____

14. Signature of Cemetery: _____

15. Signature of Funeral Home: _____

16. Signature of Mortuary: _____

17. Signature of Embalmer: _____

18. Signature of Preparator: _____

19. Signature of Assistant Embalmer: _____

20. Signature of Assistant Preparator: _____

21. Signature of Assistant Embalmer: _____

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98. Signature of Assistant Preparator: _____

99. Signature of Assistant Embalmer: _____

100. Signature of Assistant Preparator: _____

1275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORRIS (DORSEY) JAMES ENNIS</u>		4. DATE OF DEATH Month Day Year <u>January 8 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1900</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Salesman-Holt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co. Employee</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Marion T. Ennis</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Gladys H. Ennis (Wife)</u>		18. ADDRESS <u>Carey Ave. (R.D. #3) Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomp</u> <u>260x</u> DUE TO <u>Regenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>132</u> <u>2 3/4</u> <u>7-8 3/4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 9 1959</u> to <u>Jan 8 1959</u> , that I last saw the deceased alive on <u>Jan 9 1959</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Gray</u>		ADDRESS (Street, city or town, state) <u>Camden Ave. Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		DATE SIGNED <u>Jan. 8 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>Jan 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1276 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>GIRDLE TREE 23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>W.</u> Last <u>FEARN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30-1874</u>	
9. AGE (In years last birthday) <u>84 1/2</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Stridletown, Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William Ballins</u>				14. MOTHER'S MAIDEN NAME <u>Annie Pruitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr William Fearn</u>				Address <u>Stridletown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Artery Thromboses</u> <u>422.1</u> DUE TO <u>with gangrene of small intestine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>(?)</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/17</u> , 19 <u>59</u> , to <u>1/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>59</u> , and that death occurred at <u>5:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>PINEBLUFF ROAD</u> DATE SIGNED <u>1/20/59</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>				<u>SALISBURY, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 21/59</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Stridletown, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay Adams</u>				ADDRESS <u>Stridletown, Md</u>		24a. REC'D BY REGISTRAR <u>Jan 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 18 •

1277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>310 GAY STREET</u>		d. STREET ADDRESS <u>310 GAY STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W.</u> Last <u>GALE</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1895</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE GALE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>DR. REFUS JOHNSON</u>	
17. INFORMANT <u>DR. REFUS JOHNSON</u>		Address <u>SNOW HILL ROAD</u> <u>SALISBURY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolus of Brain</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Embolism.</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 31, 1958</u> , to <u>January 4, 1959</u> , that I last saw the deceased alive on <u>1/1/59</u> , 19____, and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carrie Hearn</u>		ADDRESS (Street, city or town, state) <u>226 N. Minisink St.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>CHARIE HEARN</u>		M.D. <u>226 N. Minisink St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Talley</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Farris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Residence		Occupation		Cause of Death	
123 Main St, City		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1925		10:30 AM		Home	
Physician		Burial		Interment	
Dr. Smith		St. Mary's Church		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1278 Item 6 Film G238 2-2-59 et
CERTIFICATE OF DEATH

01284

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P. G. Hospital</u>		d. STREET ADDRESS <u>23x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Erleina</u> Middle <u>Gillett</u> Last <u>Gillett</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20 - 1912</u>
9. AGE (in years) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Croch Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Gillett</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Spencer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Matilda Gillett</u>	
17. INFORMANT <u>Mrs. Matilda Gillett</u>		Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Degenerative Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 wks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 12, 1958</u> , to <u>Jan 27, 1959</u> , that I last saw the deceased alive on <u>Jan 27, 1959</u> , and that death occurred at <u>3:00 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Bender</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill, Md.</u>	
DATE SIGNED <u>Jan 27, 1959</u>			
PHYSICIAN'S NAME (Type) <u>John M. Bender</u>		ADDRESS <u>104 Bay St. Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Seaside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Harris</u>		24a. REC'D BY REGISTRAR <u>Jan 29 '59</u>	
ADDRESS <u>Snow Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1279

CERTIFICATE OF DEATH

01285

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 254 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS RFD # 3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lottie Middle Gootee Last Gootee		4. DATE OF DEATH Month Jan. Day 7 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 59 Min.	IF UNDER 24 HRS. Months 7 Days 19 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Jerome Lane		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Old cerebral thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis			
INTERVAL BETWEEN ONSET AND DEATH Years Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ?			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 28 , 19 58 , to Jan. 7 , 19 59 , that I last saw the deceased alive on Jan. 7 , 19 59 , and that death occurred at 9:55A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/7/59			
ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital 1/7/59			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-59	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park
22d. LOCATION (City, town, or county) (State) Cambridge, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE L. Compton ADDRESS Home, Cambridge, Md.			
24a. REC'D BY REGISTRAR DATE JAN 7 2 59		24b. REGISTRAR'S SIGNATURE Robert D. ...	

CERTIFICATE OF DEATH

1918

2-2-18

Name of deceased		Sex		Age		Date of birth		Place of birth	
John Doe		Male		45		Jan 15 1873		New York City	
Cause of death		Disease		Organ		Site		Nature	
Heart failure		Myocardial		Heart		Left ventricle		Coronary artery disease	
Time of death		Place of death		Physician		Signature		Title	
Jan 20 1918		Home		Dr. J. Smith		[Signature]		Physician	
Burial place		Burial date		Burial time		Burial place		Burial date	
Catholic Cemetery		Jan 22 1918		10:00 AM		Catholic Cemetery		Jan 22 1918	
Burial place		Burial date		Burial time		Burial place		Burial date	
Catholic Cemetery		Jan 22 1918		10:00 AM		Catholic Cemetery		Jan 22 1918	

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BALTIMORE, MD

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CERTIFICATE OF DEATH

Reg. Dist. No.

1322

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 78 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Kennerly Last Gravenor				4. DATE OF DEATH Month Jan. Day 29 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1880	9. AGE (In years and birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew J. Kennerly				14. MOTHER'S MAIDEN NAME Mary Margaret Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mary Russell, Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Jan 27, 1959 , to Jan 29, 1959 , that I last saw the deceased alive on Jan 29, 1959 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman M.D.			ADDRESS (Street, city or town, state) Sharptown		DATE SIGNED 2/1/59		
PHYSICIAN'S NAME (Type) H. S. Kuhlman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-1-59	22c. NAME OF CEMETERY OR CREMATORY Riverton		22d. LOCATION (City, town, or county) (State) Riverton, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Gravel, Sharptown, Md.			24a. REC'D BY REGISTRAR DATE FEB 4 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kneiss		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		78		1881		Maryland	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
None		None		None		None		None	
OCCUPATION		PROFESSION		INDUSTRY		TRADE		VOCATION	
None		None		None		None		None	
EDUCATION		SCHOOLING		REASON FOR DEATH		DATE OF DEATH		PLACE OF DEATH	
None		None		None		None		None	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
None		None		None		None		None	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01287

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pineway (Box # 83)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Pineway (Box #83)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle S Last GRIFFITH		4. DATE OF DEATH Month JAN. Day 9th Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 9th Days 9th Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bill Poster-Gen. Outdoor Adv. Co.		10b. KIND OF BUSINESS OR INDUSTRY Kenton, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Griffith		14. MOTHER'S MAIDEN NAME Susie Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 15-10-10000		17. INFORMANT Mrs. Susie A. Holloway (Mother) Pineway (Box #83) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 10 /1959	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
22d. LOCATION (City, town, or county) Salisbury, Maryland		22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Phillips Street (Friend's home)			e. STREET ADDRESS East Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle Ella Last Hall			4. DATE OF DEATH Month Jan. Day 9th Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gilbert Fleming, Berlin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO (b) Arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH year
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-13-59	
EXAMINER'S NAME (Type) Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive	
22d. LOCATION (City, town, or county) Delmar, Del.		22e. (State) Del.		22f. (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Gandy Co. Delmar Del.		ADDRESS Delmar, Del.		24a. REC'D BY REGISTRAR DATE JAN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. House					

1325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIRGIL LEE HAMMOND		4. DATE OF DEATH Month JANUARY Day 30th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Chicken Grower		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William James Hammond	
14. MOTHER'S MAIDEN NAME Rebecca E. Bethards		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. E. Blanche Hammond (Wife) R.D.# 1 Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinoma of Lung with metastases to Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November, 1958 , to January 30, 1959 , that I last saw the deceased alive on January 29, 1959 , and that death occurred at 4:35 A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Thomas C. Hill, Jr. M.D. Jan. 31, 1959			
ACTUAL SIGNATURE Thomas C. Hill, Jr.		PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF Feb. 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery (Old-Part) Pittsville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR FEB 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Harper</u> Last <u>Harper</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 1898</u>
9. AGE (In years last birthday) yrs. <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Harper</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 18</u> , 19 <u>58</u> , to <u>Jan. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 20</u> , 19 <u>59</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		M.D. <u>Deer's Head State Hospital</u> <u>1/21/59</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Meth. Ch.</u>	22d. LOCATION (City, town, or county) (State) <u>Croom MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruby S. Washington</u> ADDRESS <u>467 N. St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

16

1281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 Claborne Street		d. STREET ADDRESS 407 Claborne Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anne Harris First Middle Last		4. DATE OF DEATH January 17 Month Day Year 1959	
5. SEX female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1890 9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.a.	
13. FATHER'S NAME Lawrence Taylor		14. MOTHER'S MAIDEN NAME Mary Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ella Askin 413 Claborne St. Salis. Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-6 1957 , to 1-17 1959 , that I last saw the deceased alive on 12-22 1959 , and that death occurred at 6 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul A. Insley M.D.		ADDRESS (Street, city or town, State) Salisbury, Md. DATE SIGNED 1-20-59	
PHYSICIAN'S NAME (Type) Paul A. Insley			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/23/1959	22c. NAME OF CEMETERY OR CREMATORY green acres	22d. LOCATION (City, town, or county) (State) Salisbury Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Stewart ADDRESS Salisbury Md.		24a. REC'D BY REGISTRAR JAN 28 '59	24b. REGISTRAR'S SIGNATURE Claborne L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1282
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>209 Naylor St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James T. Hastings</u>				4. DATE OF DEATH Month Day Year <u>January 25th, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 29, 1891</u>	
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>8 26</u>		IF UNDER 24 HRS. <u>8 26</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Owner & Operator-Coal Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator-Coal Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Williamana Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Elsie E. Hastings (Wife)</u> Address <u>209 Naylor St Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1958</u> to <u>Jan. 25, 1959</u> , that I last saw the deceased alive on <u>Jan. 24, 1959</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thomas C. Hill Jr.</u> M.D. <u>Jan. 25, 1959</u>							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u> <u>Pine Bluff Road - Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILL BOND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1283

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G237 1-19-59 et

01293

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u> 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Geraldine</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1939</u>
9. AGE (in years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Showell Poultry Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hill</u>		14. MOTHER'S MAIDEN NAME <u>Marjie Odessa Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marjie Hill, R.F.D., Onancock, Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of brain</u> 919.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bystander shot while two men were fighting over gun.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:10 P.M. 1-10-59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HiHat Club</u>	20f. (City or town) (County) (State) <u>Ocean City Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Nebo Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Nebo, Accomack, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas.</u>		ADDRESS <u>Accomack, Virginia</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton A. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Undertaker: _____

18. Signature of Burial: _____

19. Signature of Cremation: _____

20. Signature of Other: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1284
CERTIFICATE OF DEATH

01294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS Mt. Hermon Rd (P.O. B#708)	
3. NAME OF DECEASED (Type or print) First EDWARD Middle CALVIN Last HOLLOWAY		4. DATE OF DEATH Month JAN. Day 10th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1911
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator (Salisbury Auto Parts)		10b. KIND OF BUSINESS OR INDUSTRY Snow Hill (R.D.) Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elijah Calvin Holloway		14. MOTHER'S MAIDEN NAME Mary C. Hottenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Pauline I. Holloway (Wife) P.O. B. #708 Mt Hermon Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion Arterio sclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH yes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-27, 1954, to 1-10, 1959, that I last saw the deceased alive on 1-10, 1959, and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland DATE SIGNED January 12/59			
ACTUAL SIGNATURE Earl L. Royer		M.D.	
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 14/1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park - Salisbury Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JAN 14 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF SHERIFF</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JURY</p>	
<p>19. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>20. SIGNATURE OF COUNTY CLERK</p>	
<p>21. SIGNATURE OF STATE CLERK</p>		<p>22. SIGNATURE OF VICE CLERK</p>	
<p>23. SIGNATURE OF DEPUTY CLERK</p>		<p>24. SIGNATURE OF ASSISTANT CLERK</p>	
<p>25. SIGNATURE OF RECORDS CLERK</p>		<p>26. SIGNATURE OF INDEXER</p>	
<p>27. SIGNATURE OF FILE CLERK</p>		<p>28. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>29. SIGNATURE OF STENOGRAPHER</p>		<p>30. SIGNATURE OF TELETYPE CLERK</p>	
<p>31. SIGNATURE OF TELEPHONE CLERK</p>		<p>32. SIGNATURE OF MAIL CLERK</p>	
<p>33. SIGNATURE OF RECEPTION CLERK</p>		<p>34. SIGNATURE OF DISPATCH CLERK</p>	
<p>35. SIGNATURE OF RECORDS CLERK</p>		<p>36. SIGNATURE OF INDEXER</p>	
<p>37. SIGNATURE OF FILE CLERK</p>		<p>38. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>39. SIGNATURE OF STENOGRAPHER</p>		<p>40. SIGNATURE OF TELETYPE CLERK</p>	
<p>41. SIGNATURE OF TELEPHONE CLERK</p>		<p>42. SIGNATURE OF MAIL CLERK</p>	
<p>43. SIGNATURE OF RECEPTION CLERK</p>		<p>44. SIGNATURE OF DISPATCH CLERK</p>	
<p>45. SIGNATURE OF RECORDS CLERK</p>		<p>46. SIGNATURE OF INDEXER</p>	
<p>47. SIGNATURE OF FILE CLERK</p>		<p>48. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>49. SIGNATURE OF STENOGRAPHER</p>		<p>50. SIGNATURE OF TELETYPE CLERK</p>	
<p>51. SIGNATURE OF TELEPHONE CLERK</p>		<p>52. SIGNATURE OF MAIL CLERK</p>	
<p>53. SIGNATURE OF RECEPTION CLERK</p>		<p>54. SIGNATURE OF DISPATCH CLERK</p>	
<p>55. SIGNATURE OF RECORDS CLERK</p>		<p>56. SIGNATURE OF INDEXER</p>	
<p>57. SIGNATURE OF FILE CLERK</p>		<p>58. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>59. SIGNATURE OF STENOGRAPHER</p>		<p>60. SIGNATURE OF TELETYPE CLERK</p>	
<p>61. SIGNATURE OF TELEPHONE CLERK</p>		<p>62. SIGNATURE OF MAIL CLERK</p>	
<p>63. SIGNATURE OF RECEPTION CLERK</p>		<p>64. SIGNATURE OF DISPATCH CLERK</p>	
<p>65. SIGNATURE OF RECORDS CLERK</p>		<p>66. SIGNATURE OF INDEXER</p>	
<p>67. SIGNATURE OF FILE CLERK</p>		<p>68. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>69. SIGNATURE OF STENOGRAPHER</p>		<p>70. SIGNATURE OF TELETYPE CLERK</p>	
<p>71. SIGNATURE OF TELEPHONE CLERK</p>		<p>72. SIGNATURE OF MAIL CLERK</p>	
<p>73. SIGNATURE OF RECEPTION CLERK</p>		<p>74. SIGNATURE OF DISPATCH CLERK</p>	
<p>75. SIGNATURE OF RECORDS CLERK</p>		<p>76. SIGNATURE OF INDEXER</p>	
<p>77. SIGNATURE OF FILE CLERK</p>		<p>78. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>79. SIGNATURE OF STENOGRAPHER</p>		<p>80. SIGNATURE OF TELETYPE CLERK</p>	
<p>81. SIGNATURE OF TELEPHONE CLERK</p>		<p>82. SIGNATURE OF MAIL CLERK</p>	
<p>83. SIGNATURE OF RECEPTION CLERK</p>		<p>84. SIGNATURE OF DISPATCH CLERK</p>	
<p>85. SIGNATURE OF RECORDS CLERK</p>		<p>86. SIGNATURE OF INDEXER</p>	
<p>87. SIGNATURE OF FILE CLERK</p>		<p>88. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>89. SIGNATURE OF STENOGRAPHER</p>		<p>90. SIGNATURE OF TELETYPE CLERK</p>	
<p>91. SIGNATURE OF TELEPHONE CLERK</p>		<p>92. SIGNATURE OF MAIL CLERK</p>	
<p>93. SIGNATURE OF RECEPTION CLERK</p>		<p>94. SIGNATURE OF DISPATCH CLERK</p>	
<p>95. SIGNATURE OF RECORDS CLERK</p>		<p>96. SIGNATURE OF INDEXER</p>	
<p>97. SIGNATURE OF FILE CLERK</p>		<p>98. SIGNATURE OF DISTRIBUTION CLERK</p>	
<p>99. SIGNATURE OF STENOGRAPHER</p>		<p>100. SIGNATURE OF TELETYPE CLERK</p>	

1285
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 200 Walnut	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Walnut St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle MELSTEAD Last HUGHES		4. DATE OF DEATH Month JAN. Day 17th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 6 Days 15	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Portsmouth, Ohio	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Cread F. Melstead		14. MOTHER'S MAIDEN NAME Ruhama Irwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. Mr. John G. Hughes (Husband)	
17. INFORMANT Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiovascular renal disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-1959 to 1-17-1959 that I last saw the deceased alive on 1-16-1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley		DATE SIGNED Jan. 19 / 1959	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		ADDRESS Main St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Meltower Cemetery		22d. LOCATION (City, town, or county) (State) Granville, New York	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SALISBURY MARYLAND	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		DATE JAN 20 '59	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Note on Page 1

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR A LICENSED NURSE.

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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CERTIFICATE OF DEATH

1286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas KEASBY Jones</u>		4. DATE OF DEATH Month Day Year <u>January 21 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Jones</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Craft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-1842</u>	
17. INFORMANT Address <u>Ethelyn Jones Sharpton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic cor pulmonale</u> <u>525x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis</u> DUE TO (c) <u>"</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-19</u> , 19 <u>59</u> , to <u>1-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>59</u> , and that death occurred at <u>6:40</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D. <u>Salisbury, Md</u> <u>1-21-59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Furnace</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marvel, Sharpton, Md</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON
1922

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of undertaker		12. Signature of witness	
13. Signature of funeral home		14. Signature of cemetery		15. Signature of burial place	
16. Signature of interment		17. Signature of cremation		18. Signature of other	
19. Signature of other		20. Signature of other		21. Signature of other	
22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
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49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1287

CERTIFICATE OF DEATH

01297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u> 23x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Cleveland</u> Middle <u>Littleton</u> Last <u>Littleton</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 - 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John T. Littleton</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-12-1737</u>	
17. INFORMANT <u>Daisy Littleton</u>		Address <u>Whaleyville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema; Chronic Bronchitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-15</u> , 19 <u>58</u> , to <u>1-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Silvers</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Jan. 8, 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Behoboth</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland, County of Baltimore, City of Baltimore, I, the undersigned, being a duly qualified and licensed physician, do hereby certify that on the _____ day of _____, 19____, at _____, Maryland, I attended _____, who died at _____, Maryland, of _____, and that the cause of death was _____.

The deceased was born on the _____ day of _____, 19____, at _____, Maryland, and was _____ years of age at the time of death. He was _____ (single, married, widowed, divorced) and was _____ (husband, wife, child, parent, etc.) of _____, who is _____ (living, deceased) and who died on the _____ day of _____, 19____, at _____, Maryland, of _____, and whose cause of death was _____.

The deceased was _____ (born, adopted) of _____, who is _____ (living, deceased) and who died on the _____ day of _____, 19____, at _____, Maryland, of _____, and whose cause of death was _____.

The deceased was _____ (born, adopted) of _____, who is _____ (living, deceased) and who died on the _____ day of _____, 19____, at _____, Maryland, of _____, and whose cause of death was _____.

The deceased was _____ (born, adopted) of _____, who is _____ (living, deceased) and who died on the _____ day of _____, 19____, at _____, Maryland, of _____, and whose cause of death was _____.

The deceased was _____ (born, adopted) of _____, who is _____ (living, deceased) and who died on the _____ day of _____, 19____, at _____, Maryland, of _____, and whose cause of death was _____.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01298

1288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 421 Hastings St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LINWOOD Middle LELAND Last MADDOX				4. DATE OF DEATH Month JAN. Day 10th Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Shirt Factory-Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unk			14. MOTHER'S MAIDEN NAME Mary Ellen Maddox				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I		17. INFORMANT Mrs. Lena M. Maddox (Wife) Address 421 Hastings St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 445x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension malignant DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1-7 , 19 59 , to 1-10 , 19 59 , that I last saw the deceased alive on 1-9 , 19 59 , and that death occurred at 7:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Salisbury, Maryland Jan 12 1959							
ACTUAL SIGNATURE W. H. Smith		M.D. Med. Center Stryker					
PHYSICIAN'S NAME (Type) Dr. William Smith		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	22d. LOCATION (City, town, or county) (State) Near Salisbury, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 14 '59	24b. REGISTRAR'S SIGNATURE Amos D. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF DECEASED</p>		<p>10. SIGNATURE OF WITNESSES</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>	
<p>13. SIGNATURE OF JUDGE</p>		<p>14. SIGNATURE OF CLERK</p>		<p>15. SIGNATURE OF REGISTRAR</p>		<p>16. SIGNATURE OF VENDOR</p>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

Item 18 & 19 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b yo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 228 Lake St.				d. STREET ADDRESS 1 228 Lake St.			
3. NAME OF DECEASED (Type or print) First John Middle McKnight Last McKnight				4. DATE OF DEATH Month 1 Day 10 Year 19 59			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 1 Days 10	IF UNDER 72 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie McKnight				14. MOTHER'S MAIDEN NAME Margaret Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT W. McKnight Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden Years							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1-15-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-59		22c. NAME OF CEMETERY OR CREMATORY Brown Row		22d. LOCATION (City, town, or county) (State) Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Stacy M. Clark				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 19 59	
						24b. REGISTRAR'S SIGNATURE Charles E. Hume	

2

STATE OF
HEALTH DEPT.

STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Death: *Jan 15, 1925*

5. Place of Death: *Home*

6. Cause of Death: *Heart Disease*

7. Manner of Death: *Natural*

8. Signature of Medical Examiner: *[Signature]*

9. Signature of Coroner: *[Signature]*

10. Signature of Registrar: *[Signature]*

11. Date of Report: *Jan 16, 1925*

12. Office of Registrar: *[Blank]*

13. Name of Registrar: *[Blank]*

14. Address of Registrar: *[Blank]*

15. City: *[Blank]*

16. State: *[Blank]*

17. County: *[Blank]*

18. District: *[Blank]*

19. Sub-District: *[Blank]*

20. Ward: *[Blank]*

21. Precinct: *[Blank]*

22. Block: *[Blank]*

23. Lot: *[Blank]*

24. Map: *[Blank]*

25. Other: *[Blank]*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01300

1290
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>15 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u>				d. STREET ADDRESS <u>612 Second Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE J. MERRILL</u>				4. DATE OF DEATH Month Day Year <u>January 3 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1880</u>		9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elackim W. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Virginia T. Truitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marion R. Merrill Jr., Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/23</u> , 19 <u>58</u> , to <u>1/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/3</u> , 19 <u>59</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>F. R. Gramse</u> M.D. <u>Salisbury, Md.</u> <u>1-3-59</u> PHYSICIAN'S NAME (Type) <u>F. R. GRAMSE</u> <u>SALISBURY, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-59</u>		22c. NAME OF CEMETERY <u>Pitts Creek Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>				24a. REC'D BY REGISTRAR ADDRESS <u>Pocomoke City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Gramse</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1291
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 877 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Catharine Last Milligan				4. DATE OF DEATH Month January Day 23 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1866	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 19 Days 23 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Revels Neck				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel James Nelson				14. MOTHER'S MAIDEN NAME Mary Bozman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 217-36-0016		17. INFORMANT Hospital Records, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 29 , 19 56 , to Jan. 23 , 19 59 , that I last saw the deceased alive on Jan. 23 , 19 59 , and that death occurred at 8:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/23/59 ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		1-23-59		Antioch Cemetery		Prince Georges Md	
23. FUNERAL DIRECTOR'S SIGNATURE Levin Wilson				ADDRESS Princess Anne		24a. REC'D BY REGISTRAR DATE JAN 27 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN IB 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
3. NAME OF DECEASED (Type or print) First ERNEST Middle MARION Last MILLS		4. DATE OF DEATH Month 1 Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 29, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Mills		14. MOTHER'S MAIDEN NAME Charlotte Ann Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-36-1122	
17. INFORMANT Louise B. Mills, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. cardiac decompensation			INTERVAL BETWEEN ONSET AND DEATH 10 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1958 to Jan 6, 1959 , that I last saw the deceased alive on Jan 6, 1959 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William H. Gray		DATE SIGNED 1/8/59	
PHYSICIAN'S NAME (Type) Dr. William H. Gray		ADDRESS (Street, city or town, state) 334 Camden Ave, Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/9/59	22c. NAME OF CEMETERY OR CREMATORY Quantico Cemetery	22d. LOCATION (City, town, or county) (State) Quantico, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co		ADDRESS Salisbury, Md.	
24a. REC'D BY REGISTRAR Norman S. Baker		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City Md. R. F. D. 123X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Perlie</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Blargen</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Craddle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>237-38-1077</u>	
17. INFORMANT <u>John A. Moore</u> Address <u>West Ocean Md. R.F.D. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>urinary and intestinal obstruction</u> DUE TO (c) <u>generalized Sarcoma & metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert Lee Bader</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stettin</u> ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 59</u>	
		24b. REGISTRAR'S SIGNATURE <u>William A. Hanna</u>	

01301

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

WILLIAM BROOKS

DOB 08-11-1884

MASSACHUSETTS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1294

CERTIFICATE OF DEATH

01304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 74 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Morgan				4. DATE OF DEATH Month January Day 16 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/1876	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 16 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY house	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Trice				14. MOTHER'S MAIDEN NAME Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of Cervix DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 19 Day 19 Year 1959 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3 , 1958, to Jan. 16 , 1959, that I last saw the deceased alive on Jan. 16 , 1959, and that death occurred at 1:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/16/59							
ACTUAL SIGNATURE L. V. Maldve		M.D. Deer's Head State Hospital 1/16/59					
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 19/59		22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or county) (State) Denton Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. J. Moore & Son				ADDRESS Denton Md		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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1295 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>316 ELLEN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Landon</u> Middle <u>T</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Patrol guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City Govt</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALEXANDER MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>CLARA HENRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-10-8883</u>		17. INFORMANT Address <u>316 ELLEN ST SALISBURY, MD</u> <u>MRS. MARGARET KIMBLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterolateral infarction</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1/30/59</u> , 19 <u> </u> , to <u>1/31/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1/31/59</u> , 19 <u> </u> , and that death occurred at <u>336</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. E. Mitchell</u>				ADDRESS (Street, city or town, state) <u>24 Maryland Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>A. C. MITCHELL</u>				DATE SIGNED <u>1/31/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES Memorial Park - Salisbury Md</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. STEWART FUNERAL HOME - Salisbury Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

21-12-22

14

1296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville, Del.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Rt. 1, 46 X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. COLUMBUS MURRAY</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 28 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 10 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Murray</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Haisey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>222-22-0580</u>		17. INFORMANT Address <u>Victor Murray Selbyville Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-23</u> , 19 <u>59</u> , to <u>1-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>59</u> , and that death occurred at <u>12:25</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willen R. Ellis, Jr. M.D. Salisbury, Md. 1-28-59</u>							
ACTUAL SIGNATURE <u>Willen R. Ellis, Jr.</u>				PHYSICIAN'S NAME (Type) <u>Willen R. Ellis, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Red Man</u>		22d. LOCATION (City, town, or county) (State) <u>Selbyville, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Whaley Selbyville, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Prange</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1930

MAILED
JAN 11 1931
BOSTON

<p>1. Name of deceased: <i>John J. Smith</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 10 1931</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. H. Brown</i></p>	
<p>8. Signature of registrar: <i>Wm. J. Smith</i></p>	
<p>9. Date of registration: <i>Jan 11 1931</i></p>	
<p>10. Place of registration: <i>Boston</i></p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1297

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Asbury</u> Middle <u>Nelson</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Kasey Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Samuel Nelson Hebron, Md. Pt #12</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>7 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peripheral Vascular Disease - gangrene - toe.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-13-59</u> , 19 <u>59</u> , to <u>1-18-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-18-59</u> , 19 <u>59</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. Gray Keen</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>			
DATE SIGNED <u>1/19/59</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockaway, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u> ADDRESS <u>Funeral Home, Salisbury, Md</u>				24. REC'D BY REGISTRAR <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: *John J. [illegible]*
 2. Date of death: *1914*
 3. Place of death: *St. Marks Cemetery, [illegible]*
 4. Cause of death: *[illegible]*
 5. Age at death: *[illegible]*
 6. Sex: *[illegible]*
 7. Race: *[illegible]*
 8. Occupation: *[illegible]*
 9. Marital status: *[illegible]*
 10. Signature of physician: *[illegible]*
 11. Signature of registrar: *[illegible]*
 12. Date of registration: *[illegible]*

DEATH CERTIFICATE
 NO. 100-21
 BOUND

1298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHOWGUS 23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>INFANT</u> Middle <u>PALMER</u> Last <u>PALMER</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 26, 1959</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>SHOWGUS MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>-</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN PALMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MRS. EDITH PALMER, SHOWGUS MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis, severe</u> 756.2 DUE TO <u>Displacement of Chest Contents</u> (b) <u>Diaphragmatic Hernia, left, with abdominal viscera in chest</u> DUE TO <u>lying cause last.</u> (c) <u>13 hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 27, 1959</u> to <u>Jan 27, 1959</u> , that I last saw the deceased alive on <u>Jan 27, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1/29/59</u>	
ACTUAL SIGNATURE <u>R. W. Samuels</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ODDFELLOWS</u>	22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annie A Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1000181XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW HAMPSHIRE STATE DEPARTMENT OF HEALTH - BURLINGTON 10

10-3004

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-10-1920</u></p>	
<p>4. Date of death: <u>10-15-1970</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>[Signature]</u></p>	
<p>8. Signature of registrar: <u>[Signature]</u></p>	
<p>9. Date of filing: <u>10-20-1970</u></p>	
<p>10. Registrar's name: <u>John Doe</u></p>	

1298
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 E. William St.,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Verta</u> Middle <u>Parsons</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 21, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Warner Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Martha E. Wimbrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Irene Todd- Same</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I attended the deceased from <u>1950</u> to <u>1/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/8/59</u> , 19 <u> </u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>1/9/59</u>							
ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D. <u>Salisbury, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Fred R. Gramse S. Division St.. Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u> ADDRESS <u>o. Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman G. Baker

CERTIFICATE OF DEATH

MASSACHUSETTS

1900

DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01310

1300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>S.</u> Last <u>PARSONS</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1921</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>Delmar, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ruben Parsons</u>		14. MOTHER'S MAIDEN NAME <u>Cora Mae Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Julia Parsons (Wife)</u>		Address <u>302 East St. Delmar, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>591x</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subacute Glomerulonephritis</u> DUE TO (c) <u>4 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Urinary Tract Infection</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:30 P. M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury Md</u> DATE SIGNED <u>Jan 2, 1959</u> PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u> Medical Center- <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Delmar, Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01311

1326
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 462 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS R.D.# 2			
3. NAME OF DECEASED (Type or print) First Oliver Middle Raymond Last Phillips				4. DATE OF DEATH Month January Day 8 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1891		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Bertram Phillips				14. MOTHER'S MAIDEN NAME Mary Hamblin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Oliver R. Phillips (Son) R.D.# Snow Hill, Md. Deer's Head State Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis 151X DUE TO Carcinoma of the stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 2, 19 57 , to Jan. 8, 19 59 , that I lost sown the deceased olive on Jan. 8, 19 59 , and that death occurred at 6:50A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/8/59			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 19 59		22c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery		22d. LOCATION (City, town, or county) (State) Worcester Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 9 '59	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1938

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
RACE [Faint, illegible text]		BIRTH DATE [Faint, illegible text]		BIRTH PLACE [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]		PLACE OF BIRTH [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF CLERK [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF JUDGE [Faint, illegible text]	

[Handwritten signature]

1301
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>608 Camden Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ROBERT WASHINGTON REVELLE</u>				4. DATE OF DEATH <u>January 26 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Saleman (Culver Motor Co.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Princess Anne, Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U S A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Sydney F. Revelle</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Heath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unk</u>			
17. INFORMANT <u>Mrs. Queenie M. Revelle (Wife)</u> Address <u>608 Camden Ave Salisbury, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/25, 1958</u> , to <u>1/26, 1958</u> , that I last saw the deceased alive on <u>1/26, 1958</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>				DATE SIGNED <u>1/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 29, 1959</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

61372

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

CERTIFICATE OF DEATH

FILE NO. 100-100000

1. NAME OF DECEASED JAMES J. CONNELLEY		2. SEX Male	
3. AGE 68		4. DATE OF BIRTH 1891	
5. PLACE OF BIRTH New York, N.Y.		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. DATE OF DEATH 1959	
11. SIGNATURE OF PHYSICIAN J. J. Connelley		12. SIGNATURE OF REGISTRAR J. J. Connelley	
13. SIGNATURE OF WITNESS J. J. Connelley		14. SIGNATURE OF DECEASED J. J. Connelley	

1302

CERTIFICATE OF DEATH

01313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Towson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
c. LENGTH OF STAY IN TB <u>7 Days</u>				d. STREET ADDRESS <u>205 Willow St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lewis LEE Richardson</u>				4. DATE OF DEATH Month Day Year <u>January 7 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1882 7-14-1892</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Preston Richardson</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET E. Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>MRS. ANNA WATSON, 205 Willow St, Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> DUE TO (b) <u>157x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>DUE TO</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-30</u> , 19 <u>58</u> , to <u>1/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/7</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Bloxom III</u> M.D.				MEDICAL CENTER, Salisbury, Md.			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III, MEDICAL CENTER, SALISBURY, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.F. Stewart Funeral Home, Salisbury, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

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PLACE OF DEATH

Resident of Barnstable

Resident of Barnstable

CERTIFICATE OF DEATH

Reg. Dist. No.

1303

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R 7 L O</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Russell</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TROLLEYS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSPORTATION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MR RUSSELL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA RUSSELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>DARCY ROSSELL-GALESTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 231X DUE TO (b) <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (c) <u>Lung Tumor, Type Undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Heart Disease with Auricular Fibrillation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>58</u> , to <u>1/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/8</u> , 19 <u>59</u> , and that death occurred at <u>5:46</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>				DATE SIGNED <u>1/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Spornel-Spaulding</u>				ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
PLACE OF DEATH		CITY		STATE		COUNTY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



1304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN IB <u>14 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALDERMAR E. SCHMIDT</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 28 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROFESSIONAL BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u>	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
13. FATHER'S NAME <u>RENOLD SCHMIDT</u>		14. MOTHER'S MAIDEN NAME <u>IDA MATEREN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WOLDWAR I</u>		17. INFORMANT Address <u>MRS. HELEN SCHMIDT, OCEAN CITY, MD</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Rheumatic Heart Disease</u> (c) <u>Hepatic Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic Insufficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>59</u> , to <u>1/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd.</u> DATE SIGNED <u>1/28/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNSTOWN</u>	22d. LOCATION (City, town, or county) (State) <u>GREENWOOD DEL</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna B. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

Page 1 of 1

Name of Deceased		WILLIAM BOND	
Date of Death		1918	
Place of Death		Baltimore, Maryland	
Cause of Death		Pneumonia	
Age at Death		45	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Laborer	
Residence		1234 Main St, Baltimore, MD	
Burial Place		Greenwood Cemetery	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1918	
Registrar's Office		Baltimore, Maryland	

1305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 82	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOTTIE MURRAY SHORES		4. DATE OF DEATH Month JAN. Day 2nd Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 8 Days 28	
11. BIRTHPLACE (State or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Smith		14. MOTHER'S MAIDEN NAME Mary Hillman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Ernest C. Shores (Husband) Address Station St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15, 1958 to Jan. 2, 1959 , that I last saw the deceased alive on Jan. 2, 1959 , and that death occurred at 3:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. David J. Gilmore		DATE SIGNED Jan. 1959	
PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis		ADDRESS (Street, city or town, state) Medical Center, Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cem.		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>		<p>4. Date of birth</p>		<p>5. Date of death</p>	
<p>6. Place of birth</p>		<p>7. Usual residence</p>		<p>8. Cause of death</p>		<p>9. Manner of death</p>		<p>10. Signature of physician</p>	
<p>11. Signature of registrar</p>		<p>12. Signature of informant</p>		<p>13. Signature of medical examiner</p>		<p>14. Signature of coroner</p>		<p>15. Signature of jury</p>	
<p>16. Signature of funeral director</p>		<p>17. Signature of undertaker</p>		<p>18. Signature of cemetery</p>		<p>19. Signature of burial place</p>		<p>20. Signature of interment</p>	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	c. LENGTH OF STAY IN 1b 1 year	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RED 3		d. STREET ADDRESS RED 3	
3. NAME OF DECEASED (Type or print) First James Middle Smith Last Smith		4. DATE OF DEATH Month Jan. Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-12-8900	
17. INFORMANT Rachel Smith, Delmar, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO (b) Arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer		DATE SIGNED 1-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Gandy Co. Delmar, Del.		24. REC'D BY REGISTRAR DATE JAN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
DEATH

STATEMENT OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. RESIDENCE		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER	
10. SIGNATURE OF WITNESS		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF MINISTER		14. SIGNATURE OF CLERGY		15. SIGNATURE OF OTHER	
16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01318

1306 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRIETT Annie FIRST MIDDLE				4. DATE OF DEATH January 21 19 59 Snelling			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 21 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Loretta, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Smullen				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. NOAE		17. INFORMANT Address Hospital Records, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent cerebral thrombosis							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 12 , 19 59 , to Jan. 21 , 19 59 , that I last saw the deceased alive on Jan. 21 , 19 59 , and that death occurred at 8:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/21/59							
ACTUAL SIGNATURE L. V. Maldve, M. D.				PHYSICIAN'S NAME (Type) Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/1959		22c. NAME OF CEMETERY OR CREMATORY ALLEN CEMETERY		22d. LOCATION (City, town, or county) (State) ALLEN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co Norman F. Baker				ADDRESS SALISBURY, MD		24c. REC'D BY REGISTRAR DATE JAN 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thacker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Duration of illness	
9. Name of physician		10. Name of attending physician		11. Name of hospital		12. Name of funeral home	
13. Name of informant		14. Name of registrar		15. Name of witness		16. Name of witness	
17. Name of witness		18. Name of witness		19. Name of witness		20. Name of witness	
21. Name of witness		22. Name of witness		23. Name of witness		24. Name of witness	
25. Name of witness		26. Name of witness		27. Name of witness		28. Name of witness	
29. Name of witness		30. Name of witness		31. Name of witness		32. Name of witness	
33. Name of witness		34. Name of witness		35. Name of witness		36. Name of witness	
37. Name of witness		38. Name of witness		39. Name of witness		40. Name of witness	
41. Name of witness		42. Name of witness		43. Name of witness		44. Name of witness	
45. Name of witness		46. Name of witness		47. Name of witness		48. Name of witness	
49. Name of witness		50. Name of witness		51. Name of witness		52. Name of witness	
53. Name of witness		54. Name of witness		55. Name of witness		56. Name of witness	
57. Name of witness		58. Name of witness		59. Name of witness		60. Name of witness	
61. Name of witness		62. Name of witness		63. Name of witness		64. Name of witness	
65. Name of witness		66. Name of witness		67. Name of witness		68. Name of witness	
69. Name of witness		70. Name of witness		71. Name of witness		72. Name of witness	
73. Name of witness		74. Name of witness		75. Name of witness		76. Name of witness	
77. Name of witness		78. Name of witness		79. Name of witness		80. Name of witness	
81. Name of witness		82. Name of witness		83. Name of witness		84. Name of witness	
85. Name of witness		86. Name of witness		87. Name of witness		88. Name of witness	
89. Name of witness		90. Name of witness		91. Name of witness		92. Name of witness	
93. Name of witness		94. Name of witness		95. Name of witness		96. Name of witness	
97. Name of witness		98. Name of witness		99. Name of witness		100. Name of witness	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>R.F.D. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Gloria Jean Terry</u>		4. DATE OF DEATH <u>1-12-1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1942</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Terry</u>		14. MOTHER'S MAIDEN NAME <u>Gladys L. Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Theoda Brooks, Mardela Springs, Md., RFD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>651.0</u> <u>Tetanus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infected abortion</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Undetermined</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Sharptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 26 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton L. Harris</u>	

1308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Pen Gen Hospital		e. STREET ADDRESS R.D.# 1	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle MARIE Last THOMPSON		4. DATE OF DEATH Month JAN. Day 1st Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Secretary)		10b. KIND OF BUSINESS OR INDUSTRY Chicken Hatchery	
11. BIRTHPLACE (State or foreign country) Staten Island, N.Y.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Becker		14. MOTHER'S MAIDEN NAME Marie Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Ida M. Nichols (Daughter) R.D.# 3 Carey Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Tuberculous			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 28, 1958 to 1-1 , 19 59 , that I last saw the deceased alive on Dec 30 , 19 58 , and that death occurred on M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D. Salisbury, Md		DATE SIGNED Jan. 2, 1959	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		Main St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove seal-ban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01321

CERTIFICATE OF DEATH

Reg. Dist. No.

1328

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown			c. LENGTH OF STAY IN 1b 91 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				d. STREET ADDRESS Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Zenephine Toadvine				4. DATE OF DEATH Month Day Year January 11, 1959				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1867		
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Jennie Walker, Sharptown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from OCT , 1956, to Jan , 1959, that I last saw the deceased alive on Jan 11 , 1959, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 714 WEST ST. LAUREL, DEL DATE SIGNED 1/13/59 ACTUAL SIGNATURE Joseph A. Elliott M.D. 714 WEST ST. LAUREL, DEL PHYSICIAN'S NAME (Type) JOSEPH A. ELLIOTT								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-59		22c. NAME OF CEMETERY OR CREMATORY Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Brand, Sharptown, Md.				24a. REC'D BY REGISTRAR DATE JAN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G237 1-19-59 et

1309

CERTIFICATE OF DEATH

01322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francell</u> <u>Walker</u>				4. DATE OF DEATH <u>January</u> <u>6</u> <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Unknown</u>	8. DATE OF BIRTH <u>July 25, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>-</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Deer's Head State Hospital Records, Salisbury, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis due to</u> <u>332 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>52</u> , to <u>Jan. 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 6</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>1/7/59</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Bld</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				24a. REC'D BY REGISTRAR <u>Jan 14 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY 23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R.R. 2</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MILDRED</u> Middle <u>E.</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM F. JARRETT</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN MYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>CARROLL C. WARD, Pocomoke City, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal + urethral obstruction</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Ovarian Carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-36</u> , 19 <u>58</u> , to <u>1-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9:50pm 1-1</u> , 19 <u>59</u> , and that death occurred at <u>10:39</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1-2-59</u>			
ACTUAL SIGNATURE <u>Robert Lee Baker</u> M.D.		PHYSICIAN'S NAME (Type) <u>ROBERT LEE BAKER</u> <u>SALISBURY MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke City, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knave</u>	

MEDICAL CERTIFICATION

2

82

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

DATE

DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

RECEIVED
BUREAU OF VITAL RECORDS
BALTIMORE, MD

RECEIVED
BUREAU OF VITAL RECORDS
BALTIMORE, MD

1311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Princess Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> 19X-2	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>BERNARD</u> First <u>H.</u> Middle <u>WATERS</u> Last		4. DATE OF DEATH <u>JANUARY 17, 1959</u> Month <u>17</u> Day <u>1959</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>II/2/1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>	
11. BIRTHPLACE (State or foreign country) <u>PRINCESS ANNE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>ANOTHY WATERS</u>		14. MOTHER'S MAIDEN NAME <u>MAYIA MADDOX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WT</u> (If yes, give war or dates of service) <u>WI</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM WATERS, PRINCESS ANNE, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Rt. Sidelap</u> 527.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lung Disease</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12/59</u> to <u>1/17/59</u> , that I lost sown the deceased alive on <u>1/17/59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>1/17/59</u>			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		DATE SIGNED <u>1/17/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR</u>		<u>Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR, PRINCESS ANNE, MD</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL SHARPTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>	
c. LENGTH OF STAY IN 1b <u>24 YRS.</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE SHADE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>WEBSTER</u> Last <u>WEBSTER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 21 - 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD DUTIES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WESLEY ABBOTT</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THOMAS WEBSTER</u>		Address <u>DEAL ISLAND MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Secondary Colon</u> <u>153.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153.2</u> DUE TO (c) <u>153.2</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 1958, to <u>Jan 16</u> , 1959, that I last saw the deceased alive on <u>Jan 15</u> , 1959, and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. S. Kuhlman</u> M.D.		DATE SIGNED <u>1/17/59</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN 18 - 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u> ADDRESS <u>Deal Island Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll & K...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <u>JOHN J. SMITH</u></p>		<p>2. SEX <u>MALE</u></p>	
<p>3. AGE <u>45</u></p>		<p>4. DATE OF BIRTH <u>1910</u></p>	
<p>5. PLACE OF BIRTH <u>NEW YORK</u></p>		<p>6. OCCUPATION <u>LABORER</u></p>	
<p>7. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED</p>		<p>8. DATE OF DEATH <u>1955</u></p>	
<p>9. TIME OF DEATH <u>10:00 AM</u></p>		<p>10. PLACE OF DEATH <u>HOME</u></p>	
<p>11. CAUSE OF DEATH <u>HEART DISEASE</u></p>		<p>12. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE</p>	
<p>13. SIGNATURE OF PHYSICIAN <u>[Signature]</u></p>		<p>14. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>15. SIGNATURE OF WITNESS <u>[Signature]</u></p>		<p>16. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>17. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>18. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>19. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>20. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>21. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>22. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>23. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>24. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>25. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>26. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>27. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>28. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>29. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>30. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>31. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>32. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>33. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>34. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>35. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>36. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>37. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>38. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>39. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>40. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>41. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>42. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>43. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>44. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>45. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>46. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>47. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>48. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>49. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>50. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>51. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>52. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>53. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>54. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>55. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>56. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>57. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>58. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>59. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>60. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>61. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>62. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>63. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>64. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>65. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>66. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>67. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>68. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>69. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>70. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>71. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>72. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>73. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>74. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>75. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>76. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>77. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>78. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>79. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>80. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>81. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>82. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>83. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>84. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>85. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>86. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>87. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>88. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>89. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>90. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>91. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>92. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>93. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>94. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>95. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>96. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>97. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>98. SIGNATURE OF DECEASED <u>[Signature]</u></p>	
<p>99. SIGNATURE OF DECEASED <u>[Signature]</u></p>		<p>100. SIGNATURE OF DECEASED <u>[Signature]</u></p>	

RECEIVED
 BALTIMORE
 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01326

1312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Berlin 23x-2	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Widic		4. DATE OF DEATH Month January Day 19th. Year 19 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ROTE SLOVENIA, JUGOSLAVIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK LUKAN		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO.	
17. INFORMANT MISS. FLORENCE WIDIC		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Alcoholism & Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1959 , to 1-19- 1959 , that I last saw the deceased alive on 19 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William H. Fisher, Jr. M.D.		ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 1-20-59	
PHYSICIAN'S NAME (Type) Dr. Wm H. Fisher, Jr. Medical Center, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/21/59	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD.
23. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		ADDRESS Berlin Md	24a. REC'D BY REGISTRAR JAN 22 59
		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. 2. 2.

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1313

CERTIFICATE OF DEATH

01327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>12 SALISBURY, MD</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl Williams</u>				4. DATE OF DEATH <u>January 11 - 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 11 - 1959</u>	
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>		IF UNDER 24 HRS. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stillborn</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ISAAC WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>LUIA M. KIRKWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Pearl Kirkwood - Pocomoke, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (Birth wt 600 gms)</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-11-1959</u> , to <u>1-11-1959</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>59</u> , and that death occurred at <u>10:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Sumichrath</u> M.D.				ADDRESS (Street, city or town, state) <u>702 Camden Ave Salisbury, Md.</u>			
DATE SIGNED <u>1/17/59</u>							
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lindsley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				ADDRESS <u>2082203XVO</u>		24a. REC'D BY REGISTRAR <u>JAN 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01328

1314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 418 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Yates		4. DATE OF DEATH Month January Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S.-Govt	
11. BIRTHPLACE (State or foreign country) Port Tobacco, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME - UNK		14. MOTHER'S MAIDEN NAME - UNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left residual hemiplegy due to cerebral thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12 , 19 57 , to Jan. 5 , 19 59 , that I last saw the deceased alive on Jan. 5 , 19 59 , and that death occurred at 1:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 1/5/59			
ACTUAL SIGNATURE V. Juerman		M.D. Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-59	
22c. NAME OF CEMETERY OR CREMATORY St Charles		22d. LOCATION (City, town, or county) (State) Glymont, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, W. H. H. H. H.		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

